Nebraska Health and Human Services System
Medical Assistance Program
LONG TERM CARE COST REPORT

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

GENERAL DATA

1. Provider Number:

2. Mailing Address:
Facility
Street, P.O.Box, Route
City State Zip Code

3. Location Address (If not as above):
Street

4. Telephone Number:
(Area Code) Number

5. Location in a Metropolitan Statistical Area:
☐ Yes ☐ No

6. Licensed as:
☐ Nursing Home ☐ Hospital

7. Long Term Care Certified for:
☐ Nursing Facility (NF) ☐ ICF/MR
(Waivered ☐ Yes ☐ No)

8. Type of Control:

Government	Proprietary	Non-Proprietary
☐ City	☐ Individual	☐ Voluntary
☐ County	☐ Partnership	Non-Profit
☐ District	☐ Corporation	
☐ State		
☐ Federal		

9. Medicare Participant:
☐ Yes ☐ No Part A
☐ Yes ☐ No Part B
If Yes: Medicare Provider Number:

Intermediary:

10. Report Period:
Mon. Day Year to Mon. Day Year

11. Report Type:
☐ Regular Report Period (July to June)
☐ Closing (July 1 to Close)
☐ Beginning (Open to June 30)

12. Facility Regular Fiscal Year
_____ to _____

13. Central Office for Chain Providers:
Reimbursement Officer:
Address:
Telephone No:

14. Accounting Records Maintained at:
Address:
Telephone No:

15. Accounting Firm:
Accountant:
Address:
Telephone No:

16. Does the facility have an annual certified audit?
☐ Yes ☐ No

printed on recycled paper

INSTRUCTIONS: Complete the LONG TERM CARE COST REPORT according to the instructions found in the Nebraska Department of Health and Human Services Finance and Support Manual at Title 471 NAC 12-012.

MAILING INSTRUCTIONS: Complete, sign and mail the ORIGINAL of this report to the Nebraska Department of Health and Human Services Finance and Support, 301 Centennial Mall South, P.O. Box 95026, Lincoln, Nebraska 68509-5026.

PREPARATION ASSISTANCE: Contact the Long Term Care Audit at (402) 471-9423.

SCHEDULE A
OCCUPANCY DATA

PART 1: Required Occupancy

	A Period Covered	B Days Covered	C Number of Licensed Beds Certified NF	D NF Only Bed Days Available
1.	/ / to / /			
	/ / to / /			
	/ / to / /			
	/ / to / /			
	/ / to / /			
2.	Total			
3.	Bed Days Subject to 50% Occupancy Limit			
4.	Bed Days Subject to 85% Occupancy Limit			

SCHEDULE A
OCCUPANCY DATA

PART 2: Census Data

	A	B	C	D	E	F	G	H	I	J	K	L	M
		Nursing Facility Services									Other Than Long Term Care in NF Certified Beds		
		Private			Nebraska Medicaid			Other NF (V.A. Etc.)					
	Month	In-House Only	Bed Hold Only	Total Days	In-House Only	Bed Hold Only	Total	In- House Only	Bed Hold Only	Total	In-House Only	Bed Hold Only	Total
1.	July												
	August												
	September												
	October												
	November												
	December												
	January												
	February												
	March												
	April												
	May												
	June												
2.	TOTALS												

3. Total NF Days _____ Total Other Days _____

4. Total days provided in apartment, residential, custodial, domicillary or other areas NOT certified for Long Term Care_____

SCHEDULE B
REVENUE AND COSTS

PART 1: Patient Revenues

Nebraska Medicaid LTC Patient Revenues

Line No.	A Category/Account Description	B Facility Trial Balance	C Amount to Offset Cost	D Part 3 Line No. To Offset
	NF Revenue From Covered Services:			
1	Room, Board and Routine Services			
2	Other Routine Charge			
	Ancillary Charges —			
3	— Physical Therapy			
4	— Occupational Therapy			
5	— Other Therapy			
6	— Patient Transportation			
7	— Programmatic Evaluation			
8	— Other Covered Ancillary			
9	Program Charge Allowance			
10				
11				
12	Total Revenue — Covered Services			
13	NF Revenue From Ancillary Services Not Covered by LTC Prog.			
14	Total NF Revenue			
15				
16				
17				
18				
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20				
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27				
28				

SCHEDULE B
REVENUE AND COSTS

PART 1: Patient Revenues

Private LTC Patient Revenues

Line No.	A Category/Account Description	B Facility Trial Balance	C Amount to Offset Cost	D Part 3 Line No. To Offset
	NF Revenue From Covered Services:			
29	Room, Board and Routine Services			
30	Other Routine Charge			
	Ancillary Charges —			
31	— Physical Therapy			
32	— Occupational Therapy			
33	— Other Therapy			
34	— Patient Transportation			
35	— Programmatic Evaluation			
36	— Other Covered Ancillary			
37	Charity and Courtesy Allowances	( )		
38	Bad Debts	( )		
39	Other Revenue Deduction	( )		
40	Total Revenue — Covered Services			
41	NF Revenue From Ancillary Services Not Covered by LTC Prog.			
42	Total NF Revenue			
43				
44				
45				
46				
47				
48				
49				
50				
51				
52				
53				
54				
55				
56				

SCHEDULE B
REVENUE AND COSTS

PART 1: Patient Revenues

Nebraska Medicaid LTC Patient Revenues

	A	B	C	D
Line No.	Category/Account Description	Facility Trial Balance	Amount to Offset Cost	Part 3 Line No. To Offset
	NF Revenue From Covered Services:			
1	Room, Board and Routine Services			
2	Other Routine Charge			
	Ancillary Charges —			
3	— Physical Therapy			
4	— Occupational Therapy			
5	— Other Therapy			
6	— Patient Transportation			
7	— Programmatic Evaluation			
8	— Other Covered Ancillary			
9	Program Charge Allowance			
10				
11				
12	Total Revenue — Covered Services			
13	NF Revenue From Ancillary Services Not Covered by LTC Prog.			
14	Total NF Revenue			
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
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26				
27				
28				

SCHEDULE B
REVENUE AND COSTS

PART 1: Patient Revenues

Private LTC Patient Revenues

	A	B	C	D
Line No.	Category/Account Description	Facility Trial Balance	Amount to Offset Cost	Part 3 Line No. To Offset
	NF Revenue From Covered Services:			
29	Room, Board and Routine Services			
30	Other Routine Charge			
	Ancillary Charges —			
31	— Physical Therapy			
32	— Occupational Therapy			
33	— Other Therapy			
34	— Patient Transportation			
35	— Programmatic Evaluation			
36	— Other Covered Ancillary			
37	Charity and Courtesy Allowances	( )		
38	Bad Debts	( )		
39	Other Revenue Deduction	( )		
40	Total Revenue — Covered Services			
41	NF Revenue From Ancillary Services Not Covered by LTC Prog.			
42	Total NF Revenue			
43				
44				
45				
46				
47				
48				
49				
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51				
52				
53				
54				
55				
56				

SCHEDULE B
REVENUE AND COSTS

PART 2: Other Revenue				
	A	B	C	D
Line No.	Category/Account Description	Facility Trial Balance	Amount to Offset Cost	Part 3 Line No. To Offset
1	Gifts and Grants, Rest. — Fixed Asset			
2	Gifts and Grants, Restricted — Other			
3	Gifts and Grant, Unrestricted			
4	Investment Revenue — Oper. Funds			
5	Invest. Revenue — Bond Reserve Fund			
6	Invest. Revenue Gifts and Grants Fund			
7	Interest from Late Charges			
8	Meals Sold to Employees and Guests			
9	Meals on Wheels			
10	Telephone Charges			
11	Personal Purchases Reimbursements			
12	Sale of Supplies			
13	Rental of Non-Patient Fac. and Equip.			
14	Purchase Discounts			
15	Rebates and Returns			
16	Vending			
17	Outpatient Revenue			

SCHEDULE B
REVENUE AND COSTS

PART 2: Other Revenue				
	A	B	C	D
Line No.	Category/Account Description	Facility Trial Balance	Amount to Offset Cost	Part 3 Line No. To Offset
18	Barber/Beauty Shop Revenue			
19	Interest on Funded Depreciation			
	Other Accounts:			
20	Net Intergovernmental Transfer			
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47	Total Other Revenue — Part 2			

SCHEDULE B
REVENUES AND COSTS

PART 3: Costs and Allocations

Line No.	A Cost Category/ Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Administration:								
1	Salary and Wages — Administrator								1
2	Other Compensation — Administrator								2
	Salary, Wages, and other Compensation —								
3	— Assistant Administrator								3
4	— Other								4
5	Payroll Taxes								5
6	Employee Benefits								6
7	Management Fees/Central Office Administrat.								7
8	Legal and Accounting Services								8
9	Board Fees					3			9
10	Board Meeting Costs								10
11	Office Supplies								11
12	Printing and Postage/Newsletter								12
13	Total Telephone Cost								13
14	Professional Liability Insurance								14
15	Licenses								15
16	Association Dues								16
17	Education and Training								17
18	Travel								18
19	Advertising								19
20	Donations					3			20
21	Fund Raising Cost					3			21
22	Life Insurance on Officers and Owners								22
23	Short Term Equipment Rental								23
24	Group Buying Service Cost								24
25	Other Costs — Reimbursable:								25
26									26
27									27
28									28
29									29
30									30
31									31
32	Other Costs — Not Reimbursable					3			32
33	Revenue Offsets Not Identified to a Specific Account								33
34	Total Administration Cost								34

SCHEDULE B
REVENUES AND COSTS

PART 3: Costs and Allocations

A		B	C	D	E	F	G	H	
Line No.	Cost Category/ Account Description	Facility Trial Balance	Revenue Offsets	Cost Report Adjustments	Cost For Allocation	Allocation Basis No.	Allowable NF	Unallowable and Other	Line No.
	General:								
35	Payroll Taxes — FICA				0	0			35
36	Other Payroll Taxes				0	0			36
	Employee Benefits —								
37	— Worker Compensation Insurance				0	0			37
38	— Health Insurance				0	0			38
39	— Life Insurance				0	0			39
40	— Retirement				0	0			40
41	— Other Employee Benefits — Reimburs.				0	0			41
42					0	0			42
43					0	0			43
44	— Other Employee Benefits — Not Reimb.					3			44
45	Total General Cost								45
	Dietary:								
	Salaries, Wages and Other Compensation								
46	— Dietician								46
47	— Cooks								47
48	— Other								48
49	Payroll Taxes								49
50	Employee Benefits								50
51	Consultant — Dietician								51
52	Other Purchased Services								52
53	Food								53
54	Supplies								54
55	Education and Training								55
56	Travel								56
57	Short Term Equipment Rental								57
58	Other Costs — Reimbursable:								58
59									59
60									60
61	Other Costs — Not Reimbursable					3			61
62	Revenue Offsets Not Identifiable to a Specific Account								62
63	Total Dietary Cost								63

SCHEDULE B
REVENUES AND COSTS

PART 3: Costs and Allocations

Line No.	A Cost Category/ Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Housekeeping:								
64	Salaries, Wages and Other Compensation								64
65	Payroll Taxes								65
66	Employee Benefits								66
67	Purchased Services								67
68	Education and Training								68
69	Travel								69
70	Supplies								70
71	Short Term Equipment Rental								71
72	Other Costs — Reimbursable:								72
73									73
74									74
75									75
76	Other Costs — Not Reimbursable					3			76
77	Revenue Offsets Not Identifiable to a Specific Account								77
78	Total Housekeeping Cost								78
	Laundry:								
79	Salaries, Wages and Other Compensation								79
80	Payroll Taxes								80
81	Employee Benefits								81
82	Purchased Services								82
83	Education and Training								83
84	Travel								84
85	Linens								85
86	Supplies								86
87	Short Term Equipment Rental								87
88	Other Costs — Reimbursable:								88
89									89
90									90
91	Other Costs — Not Reimbursable					3			91
92	Revenue Offsets Not Identifiable to a Specific Account								92
93	Total Laundry Cost								93

SCHEDULE B
REVENUES AND COSTS

PART 3: Costs and Allocations

Line No.	A Cost Category/ Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Nursing Services:								
94	Salaries, Wages, and Other Compensation —								94
95	— Director of Nursing								95
96	— Registered Nurses								96
97	— Practical Nurses								97
98	— Care Staff and Aides								98
99	— Medical Records								99
100	— Other Direct Care Nursing								100
101	Payroll Taxes								101
102	Employee Benefits								102
103	Consulting Registered Nurse								103
104	Purchased Services — Direct Care								104
105	Other Consulting Services (i.e. P.T., Pharm.)								105
106	Education and Training								106
107	Travel								107
108	Dues and Subscriptions								108
109	Supplies								109
110	Routine Oxygen Supply								110
111	Short Term Equipment Rental								111
112	Other Costs — Reimbursable:								112
113									113
114									114
115									115
116									116
117									117
118									118
119									119
120									120
121									121
122									122
123									123
124									124
125						3			125
126	Other Costs — Not Reimbursable								126
127	Revenue Offsets Not Identif.to a Spec. Account								127
128	Total Nursing Cost								128

SCHEDULE B
REVENUES AND COSTS

PART 3: Costs and Allocations

Line No.	A Cost Category/ Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Plant Related:								
129	Salaries, Wages and Other Compensation								129
130	Payroll Taxes								130
131	Employee Benefits								131
132	Contracted Services								132
133	Education and Training								133
134	Travel								134
135	Supplies								135
136	Vehicle Gasoline, Repairs and Maintenance								136
137	Other Equipment Repairs and Maintenance								137
138	Building Repairs and Maintenance								138
139	Natural Gas, Fuel, Oil and Propane								139
140	Electricity								140
141	Water and Sewage								141
142	Refuse Service								142
143	Cable Television Service								143
144	Insurance (i.e., Boiler, Building, Auto)								144
145	Short Term Equipment Rental								145
146	Other Costs -- Reimbursable:								146
147									147
148									148
149									149
150									150
151									151
152									152
153									153
154									154
155									155
156									156
157									157
158									158
159									159
160									160
161	Other Costs -- Not Reimbursable					3			161
162	Revenue Offsets Not Identifiable to a Specific Account								162
163	Total Plant Related Cost								163

SCHEDULE B
REVENUES AND COSTS

PART 3: Costs and Allocations

Line No.	A Cost Category/ Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Activities and Social Services:								
	Salaries, Wages and Other Compensation —								
164	— Activities								164
165	— Social Services								165
166	Payroll Taxes								166
167	Employee Benefits								167
168	Purchased Services								168
169	Consultants								169
170	Education and Training								170
171	Travel								171
172	Activities Resident Transportation								172
173	Dues and Subscriptions								173
174	Supplies								174
175	Short Term Equipment Rental								175
176	Other Costs — Reimbursable:								176
177									177
178									178
179									179
180									180
181									181
182	Other Costs — Not Reimbursable					3			182
183	Revenue Offsets Not Identifiable to a Specific Account								183
184	Total Activities and Social Services Cost								184
185	Other Revenue Offsets to Operating Cost Not Specifically Identifiable to a Category								185
186	Total Operating Cost								186

SCHEDULE B
REVENUES AND COSTS

PART 3: Costs and Allocations

Line No.	A Cost Category/ Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Physical Therapy:								
187	Salaries, Wages and Other Compensation					3			187
188	Payroll Taxes					3			188
189	Employee Benefits					3			189
190	Purchased Services					3			190
191	Short Term Equipment Rental					3			191
192	Other Costs — Reimbursable					3			192
193	Revenue Offsets Not Identifiable to a Specific Account					3			193
194	Total Physical Therapy Cost								194
	Occupational Therapy:								
195	Salaries, Wages and Other Compensation					3			195
196	Payroll Taxes					3			196
197	Employee Benefits					3			197
198	Purchased Services					3			198
199	Short Term Equipment Rental					3			199
200	Other Costs — Reimbursable					3			200
201	Revenue Offsets Not Identifiable to a Specific Account					3			201
202	Total Occupational Therapy Cost								202
	Respiratory Therapy:								
203	Salaries, Wages and Other Compensation								203
204	Payroll Taxes								204
205	Employee Benefits								205
206	Purchased Services								206
207	Short Term Equipment Rental								207
208	Other Costs — Reimbursable								208
209	Revenue Offsets Not Identifiable to a Specific Account								209
210	Total Other Reimbursable Therapy Cost								210

SCHEDULE B
REVENUES AND COSTS

PART 3: Costs and Allocations

Line No.	A Cost Category/ Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Resident Transportation — Medical:								
211	Salaries, Wages and Other Compensation								211
212	Payroll Taxes								212
213	Employee Benefits								213
214	Purchased Services								214
215	Mileage Reimbursement								215
216	Short Term Equipment Rental								216
217	Other Costs — Reimbursable								217
218	Revenue Offsets Not Identifiable to a Specific Account								218
219	Total Resident Transportation								219
220	Total Programmatic Evaluations								220
221	Other Revenue Offsets Not Identifiable to a Specific Covered Ancillary Category								221
222	Total Covered Ancillary Cost								222
	Other Ancillary — Not Covered:								
223	Pharmacy — Salaries and Other					3			223
224	Drugs and Medications					3			224
225	Radiology — Salaries and Other					3			225
226	Physician Services — Salaries and Other					3			226
227	Dental Services — Salaries and Other					3			227
228	Other Practioners Services—Salaries and Other					3			228
229	Oxygen Over 1 K Tank in 3 Days					3			229
230	Other Ancillary Services Not Covered					3			230
231	Total Ancillary Cost — Not Covered								231
232	Total Ancillary Cost								232

SCHEDULE B
REVENUES AND COSTS

PART 3: Costs and Allocations

Line No.	A Cost Category/ Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Fixed Costs:								
233	Depreciation (complete Schedule D)								233
234	Interest (complete Schedule E)								234
	Long Term Lease Cost (complete Schedule F)								
235	— Building and Permanent Equipment Lease								235
236	— Vehicle Leases								236
237	— Other Long Term Equipment Leases								237
238	Real Estate Tax								238
239	Personal Property Tax								239
240	Amortization — Start-Up Cost								240
241	Amortization — Organization Cost								241
242	Amortization — Bond Expenses								242
243	(Gains) Losses on Personal Property								243
244	Other Fixed Costs — Reimbursable:								244
245									245
246									246
247	Other Fixed Costs — Not Reimbursable					3			247
248	Revenue Offsets Not identifiable to a Specific Account								248
249	Total Fixed Cost								249
Line No.	Cost Category/ Account Description	Facility Trial Balance	Revenue Offsets	Cost Report Adjustments	Cost For Allocation	Allocation Basis No.	Allowable NF	Unallowable and Other	Line No.
	Cost Centers — Not Reimbursable:								
250	Direct Cost — Beauty and Barber Services					3			250
251	Direct Cost — Canteen/Cafeteria/Vending					3			251
252	Direct Cost — Apartments					3			252
253	Direct Cost — Residential Services					3			253
254	Direct Cost — Hospital Services					3			254
255	Other Cost Centers — Not Reimbursable:					3			255
256						3			256
257						3			257
258	Total Cost Centers — Not Reimbursable								258

SCHEDULE B
REVENUES AND COSTS

PART 4: Revenue and Cost Summary			
	A		B
Line No.	Category		Amount
	Revenues		
1	Total Patient Revenue		Schedule B, Part 1, Column B, Line 112
2	Total Other Revenue		Schedule B, Part 2, Column B, Line 47
3	Total Revenue		
	Costs		
4	Administration		Schedule B, Part 3, Column B, Line 34
5	General		Schedule B, Part 3, Column B, Line 45
6	Dietary		Schedule B, Part 3, Column B, Line 63
7	Housekeeping		Schedule B, Part 3, Column B, Line 78
8	Laundry		Schedule B, Part 3, Column B, Line 93
9	Nursing		Schedule B, Part 3, Column B, Line 128
10	Plant		Schedule B, Part 3, Column B, Line 163
11	Activities and Social Services		Schedule B, Part 3, Column B, Line 184
12	Total Operating Cost		Schedule B, Part 3, Column B, Line 186
13	Total Ancillary Cost		Schedule B, Part 3, Column B, Line 232
14	Total Fixed Cost		Schedule B, Part 3, Column B, Line 249
15	Total Cost Centers — Not Reimbursable		Schedule B, Part 3, Column B, Line 258
16	Total Costs		
	Income		
17	Net Income Before Tax		
18	Income Tax Provision		
19	Net Income After Tax		

SCHEDULE B-1
GENERAL COST ALLOCATION AND ADJUSTMENT

A		B	C	D	E	F	G	H	I	J	K	L	M	N	O
			FICA Allocation					Other Payroll Tax					Fringe Benefits		
Line No.	Payroll Category	Salaries, Wages, Other Comp. Reported	Exemption	Allocation Basis	Percentage	Adjustment Inc/(Dec)	Line No. Adjust	Exemption	Allocation Basis	Percentage	Adjustment Inc/(Dec)	Line No Adjust	Percentage	Adjustment Inc/(Dec)	Line No. Adjust
1	Administrator						5					5			6
2	Assistant Administrator						5					5			6
3	Other Admin. Personnel						5					5			6
4	Dietician						49					49			50
5	Cooks						49					49			50
6	Other Dietary Personnel						49					49			50
7	Housekeeping						65					65			66
8	Laundry						80					80			81
9	Director of Nursing						100					100			101
10	Registered Nurses						100					100			101
11	Practical Nurses						100					100			101
12	Care Staff and Aides						100					100			101
13	Medical Records						100					100			101
14	Other Direct Care Nursing						100					100			101
15	Plant Related						130					130			131
16	Activities						166					166			167
17	Social Services						166					166			167
18	Physical Therapy						188					188			189
19	Occupational Therapy						196					196			197
20	Other Therapy						204					204			205
21	Resident Transportation						212					212			213
22	Other Ancillary Personnel						230					230			230
23	Other Cost Ctrs. Person.						255					255			255
24	Total				100.00%					100.00%			100.00%		
						Total Reduces Sched. B, Part 3, Line No. 35 to 0					Total Reduces Sched. B, Part 3, Line No. 36 to 0			Total Reduces Sched. B, Part 3, Line No. 37-43 to 0	

SCHEDULE B-2
TRANSACTIONS WITH RELATED ORGANIZATIONS — REPORT AND ADJUSTMENTS

This part must be completed if any costs reported on Schedule B, Part 3 other than Leases, Interest or Depreciation, include transactions with related organizations. For related organization: Leases, complete Schedule F; Interest, complete Schedule E and Depreciation, complete Schedule D.

	A	B	C	D	E	F	G	H	I
		Percent of Ownership		Common Owners					
	Name of Related Organization or Individual	Related Organization in Nursing Home	Nursing Home in Related Organization	Percent Ownership in Nursing Home	Percent Ownership in Related Firm	Purchases from Related Organization in the Amount Of	* Cost to Related Organ. of Services/ Items Purchased	Amount to (Increase) Amount to Decrease Cost (Col. F — G)	Schedule B Line Number
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

* If the related organization qualifies for exception to the limitation write "Exception" in Column G and enter 0 in Column H.

Use copies of this page if additional lines are needed.
COPY_____ OF_____

SCHEDULE B-3
COMPENSATION OF OWNERS, DIRECTORS AND OTHER RELATED PARTIES — REPORT AND ADJUSTMENT

This Part must be completed if any costs reported on Schedule B, Part 3 include salaries, wages or other compensation paid to owners, officers or persons related to an officer or owner. Attach specific job description for each position listed.

	A	B	C	D	E	F	G	H	I
	Name of Individual	Position (Attach Job Description)	Documented Percentage of 40 Hour Wks.	Relation. and Percentage Owned	Account	Amount Per Trial Balance	Amount Allowable	Amount to Decrease	Schedule B Line Number
1					a. Salary, Wages and Other Compensation				
					b. Payroll Taxes				
					c. Fringe Benefits				
					d.				
					e.				
2					a. Salary, Wages and Other Compensation				
					b. Payroll Taxes				
					c. Fringe Benefits				
					d.				
					e.				
3					a. Salary, Wages and Other Compensation				
					b. Payroll Taxes				
					c. Fringe Benefits				
					d.				
					e.				
4					a. Salary, Wages and Other Compensation				
					b. Payroll Taxes				
					c. Fringe Benefits				
					d.				
					e.				
5					a. Salary, Wages and Other Compensation				
					b. Payroll Taxes				
					c. Fringe Benefits				
					d.				
					e.				

Use copies of this page if additional lines are needed.

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SCHEDULE B-4
OTHER COST ADJUSTMENTS

	A Adjustment Description	B Amount to Increase Cost	C Amount to Decrease Cost	D Line No. to Adjust
1	Fund Raising Cost:			
	a. Salaries			
	b. Payroll Taxes			
	c. Fringe Benefits			
	d. Other			
2	Private Duty Nurses and Aides			
	a. Salaries			
	b. Payroll Taxes			
	c. Fringe Benefits			
3	Unallowable Payroll:			
	a. Salaries			
	b. Payroll Taxes			
	c. Fringe Benefits			
4	Fees Paid Board of Directors			
5	Unallowable Management Fees			
6	Yellow Pages Display Advertis. in Excess of an Alpha Listing or Outside Immediate Service Area			
7	Other Promotional Advertising, (TV, Radio, Publications, etc.,)			
8	Membership Dues and Costs (Social and Fraternal Organizat.)			
9	Travel and Entertainment; Other Than For Professional Meetings and Direct Operations of the Home			
10	Donations			
11	Non-Reimbursed Use of Facility's Vehicles/Equipment for Non-Facility Purposes			

SCHEDULE B-4
OTHER COST ADJUSTMENTS

	A Adjustment Description	B Amount to Increase Cost	C Amount to Decrease Cost	D Line No. to Adjust
12	Life Insurance Premiums on Owners and Officers			
13	Political Contributions (Includes PAC's)			
14	Drugs Not Identified on Schedule B, Part 3, Line 224			
15	Resident Luxury Items (Personal Phones, etc.,)			
16	Fines and Penalties			
17	Real Estate and Property Taxes Not Related to Patient Care			
18	Interest on Loans Exceeding 80% of Fixed Asset Cost From Schedule E, Part 2			
19	Related Party Interest Cost From Schedule E, Part 1			
20	Non-Nursing Home Operations Interest Cost From Schedule E, Part 1			
21	Depreciation Adjustment From Schedule D, Part 1			
22	Lease Costs Limited to Owners Cost (Sch. F Part 1) a. Bldg & Perm Equip			
	b. Vehicle			
	c. Other Long Term			
23	Actual Cost of Ownership (Leases) (From Sch. F Part 1) a. Depreciation			
	b. Interest			
	c. Other			
	d.			

SCHEDULE B-4
OTHER COST ADJUSTMENTS

	A Adjustment Description	B Amount to Increase Cost	C Amount to Decrease Cost	D Line No. to Adjust
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

SCHEDULE B-4
OTHER COST ADJUSTMENTS

	A Adjustment Description	B Amount to Increase Cost	C Amount to Decrease Cost	D Line No. to Adjust
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				

This schedule is to be used only for adjustments to Schedule B, Part 3.

Similar schedules are included for other adjustments to other report schedules.

Use copies of this page if additional lines are needed

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SCHEDULE B-5
STATISTICAL DATA FOR ALLOCATIONS

A	B	C	D		
Basis No.	Allocation Basis	Total	Statistics for Allocation NF	Other	
0	Actual Costs are Identified	100.00%	100.00%	0.00%	
1	Entire Account is NF				
2	Not Used				
3	Entire Account is Not Reimbursed	100.00%	0.00%	100.00%	
4	Inpatient Days				
	Percent of Total	100.00%	. %	.	%
5	Licensed Beds				
	Percent of Total	100.00%	. %	.	%
6	Meals Served				
	Percent of Total	100.00%	. %	.	%
7	Laundry Pounds				
	Percent of Total	100.00%	. %	.	%
8	Square Feet				
	Percent of Total	100.00%	. %	.	%
9	Accumulated Cost Except Adm.				
	Percent of Total	100.00%	. %	.	%
10					
	Percent of Total	100.00%	. %	.	%
11					
	Percent of Total	100.00%	. %	.	%
12					
	Percent of Total	100.00%	. %	.	%
13					
	Percent of Total	100.00%	. %	.	%
14					
	Percent of Total	100.00%	. %	.	%
15					
	Percent of Total	100.00%	. %	.	%
16					
	Percent of Total	100.00%	. %	.	%

SCHEDULE B-5
STATISTICAL DATA FOR ALLOCATIONS

A	B	C	D		
Basis No	Allocation Baiss	Total	Statistics for Allocation NF	Other	
17	Percent of Total	100.00%	. %	.	%
18	Percent of Total	100.00%	. %	.	%
19	Percent of Total	100.00%	. %	.	%
20	Percent of Total	100.00%	. %	.	%
21	Percent of Total	100.00%	. %	.	%
22	Percent of Total	100.00%	. %	.	%
23	Percent of Total	100.00%	. %	.	%
24	Percent of Total	100.00%	. %	.	%
25	Percent of Total	100.00%	. %	.	%
26	Percent of Total	100.00%	. %	.	%
27	Percent of Total	100.00%	. %	.	%
28	Percent of Total	100.00%	. %	.	%
29	Percent of Total	100.00%	. %	.	%
30	Percent of Total	100.00%	. %	.	%
31	Percent of Total	100.00%	. %	.	%

SCHEDULE C
COMPARATIVE BALANCE SHEET

	A Assets	B Previous Year Ending	C Current Year Ending
	Current Assets		
1	Cash on Hand		
2	Checking Account		
3	Savings Account		
4	Accounts Receivable — Private		
5	Accounts Receivable — Medicaid		
6	Accounts Receivable — Other		
7	Inventories		
8	Prepaid Expenses		
9	Loans to Related Parties		
10	Short Term Investments		
11	Other:		
12			
	Long Term Assets		
13	Land		
14	Land Improvements		
15	Accumulated Depreciation Land Improvements		
16	Building and Additions		
17	Accumulated Depreciation Bldg & Additions		
18	Furniture and Equipment		
19	Accumulated Depreciation Furniture & Equip.		
20	Vehicles		
21	Accumulated Depreciation Vehicles		
22	Leasehold Improvements and Additions		
23	Accumul. Depreciation Leasehold Imp. & Add.		
24	Start-Up, Organization and Bond Costs		
25	Accumul. Amort.Start-Up,Organiz. & Bond Cost		
26	Other		
27	Accumulated Depreciation Other		
28	Funded Depreciation		
29	Bond Sinking Fund		
30	Long Term Investments		
	Intangibles		
31	Goodwill		
32	Other:		
33			
34	Total Assets		

SCHEDULE C
COMPARATIVE BALANCE SHEET

	A Liabilities and Equity	B Previous Year Ending	C Current Year Ending
	Current Liabilities		
35	Salaries and Wages Payable		
36	Payroll Taxes Payable		
37	Real Estate and Property Taxes Payable		
38	Income Tax Payable		
39	Loans From Related Parties		
40	Current Portion of Long Term Debt		
41	Short Term Notes Payable		
42	Accounts Payable		
43	Other:		
	Long Term Liabilities		
44	Mortgage Payable		
45	Bonds Payable		
46	Notes Payable		
47	Loans From Related Parties		
48	Other:		
49	Total Liabilities		
	Equity		
	Corporation:		
50	Capital Stock		
51	Paid in Capital		
52	Retained Earnings		
53			
54	Non-Profit Organization Equity		
55			
	Partnership and Proprietorship:		
56	Partner/Proprietory Capital Account		
57	Partner/Proprietory Drawing Account		
58			
	Other Equity Accounts:		
59	Intercompany Account		
60	Other:		
61			
62	Total Equity		
63	Total Liabilities and Equity		

SCHEDULE D
DEPRECIATION COST

PART 1: Depreciation Schedule Summary

Line No.	A Description of Property	B Date Acquired	C Trial Balance	D Cost Adjustments	E Cost Long Term Care Value	F Salvage Value	G Depreciation Method Required	H Useful Life	J Prior Years Depreciation	K Depreciation Cost	L Medicaid Book Value
1	Land						SL				
2	Land Improvements						SL				
3							SL				
4											
5	Main Buildings						SL				
6	Building Additions						SL				
7							SL				
8											
9	Original Furniture						SL				
10	Furniture Additions						SL				
11											
12							SL				
13	Original Equipment						SL				
14	Equipment Additions						SL				
15											
16							SL				
17	Vehicles						SL				
18							SL				
19											
20	Leasehold Improvements						SL				
21	Leasehold Additions						SL				
22											
23							SL				
24	Other:						SL				
25							SL				
26											
27	Lessor's Cost (From Sch. E)										
28	Totals										
29	Depreciation from Trial Balance (Schedule B, Part 3, Column B, Line 233)										
30	Depreciation Adjustment to Long Term Care Allowable Cost (Line 28 minus Line 29)										

Enter on Schedule B-4 Line 21

SCHEDULE D
DEPRECIATION COST

PART 2: Current Report Period Additions

A	B		D	E	F	G	H		J
Specific Item Description	Date Acquired		Useful Life	Depreciation Method Required	Original Cost	Salvage Value	Current Year Depreciation Cost		Schedule D Part 1 Line No.
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
Totals									

PART 3: Current Report Period Deletions

A	B	C	D	E	F	G	H	I	J
Specific Item Description	Date Acquired	Date of Disposal	Useful Life	Depreciation Method Required	Original Cost	Salvage Value	Current Year Depreciation Cost	Accumulated Depreciation	Schedule D Part 1 Line No.
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
Totals									

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SCHEDULE D-1
DEPRECIATION SCHEDULE ADJUSTMENTS

	A	B	C	D
	Adjustment Description	Amount to Increase Cost	Amount to Decrease Cost	Sched. D Line No. to Adjust
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

SCHEDULE D-1
DEPRECIATION SCHEDULE ADJUSTMENTS

	A	B	C	D
	Adjustment Description	Amount to Increase Cost	Amount to Decrease Cost	Sched. D Line No. to Adjust
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				

This schedule is to be used only for adjustments to Schedule D, Part 1.

Similar schedules are included for other parts of the report.

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SCHEDULE E
INTEREST COST

PART 1: Loans and Interest Cost Summary

This part of Schedule E must be completed if any interest cost is included on Schedule B, Part 3.
Attach one copy of the signed loan agreement for all loans originated or refinanced during the report period.

	A		B	C	Variable (V)	D	E	F	G	H	J	K	L
								Ending Loan Balance			Interest Cost		
	Source / Security and Purpose	Related Parties (X)	Date of Origin / Date Mature	Original Loan Amount		Interest Rate	Adjusted Beginning Loan Balance	Trial Balance	Adjustments	Adjusted Ending	Paid to Unrelat. Parties	Paid to Relat. Parties	Non-Nursing Facility Operat.
1													
2													
3													
4													
5													
6													
7													
8													
9													
10	Lessor's Cost (Schedule F)												
11	Grand Total												
12	Total Related Parties						0			0		Enter on Sch. B-4 Line 19	Enter on Sch. B-4 Line 20
13	Total Non-Nursing Home						0			0			
14	Total Unrelated Parties												

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SCHEDULE E
INTEREST COST

PART 2: Interest Limitation Computation

Either Option 1 or Option 2 may be used to compute the limitation. If Option 2 is used all subsequent reports must also use Option 2.

OPTION 1: Annual Average

1	Ending Loan Balance Unrelated Parties Schedule E, Part 1, Column H, Line 14	
2	Asset Cost — Long Term Care Value Schedule D, Part 1, Column E, Line 28	
3	DEFRA Asset Cost — Long Term Care Schedule D-1 Adjustments for DEFRA	
4	Total Asset Cost — Long Term Care Line 2 Plus Line 3	
5	80% of Fixed Asset Cost Line 4 Times 0.80	
6	Difference Line 1 Minus Line 5	

	If Line 6 is 0 or negative amount, skip to line 12 and enter 0.	
7	Beginning Loan Balance — Unrelated Parties Schedule E, Part 1, Column E, Line 14	
8	Ending Loan Balance — Unrelated Parties Schedule E, Part 1, Column H, Line 14	
9	Average Loan Balance — Unrelated Parties Divide the Total of Line 7 Plus Line 8 by 2	
10	Interest Paid to Unrelated Parties Schedule E, Part 1, Column J, Line 11	
11	Average Interest Rate Line 10 Divided by Line 9	
12	Interest Limitation Line 6 Times Line 11 (Enter on Schedule B-4, Line 18)	

OPTION 2: Monthly Average

	A Date (1)	B Total All Interest Bearing Loans	C Total Related Party Interest Bearing Loans	D Total Non-Nursing Home Loans	E Allowable Loan Balance Col B — Col C & D	F Cost of Fixed Assets Related To Care (2)	G 80% of Asset Cost (80% of Col. F)	H Loan Balan. Over 80% of Asset Cost Col. E — Col. G	I Average Interest Rate	J Interest Adjust. (Col. H X Col I ÷ by No. of Months)
1	July 1									
2	July 31									
3	August 31									
4	September 30									
5	October 31									
6	November 40									
7	December 31									
8	January 31									
9	February 28/29									
10	March 31									
11	April 30									
12	May 31									
13	June 30									
14	Totals									
15	Monthly Average									Enter on Sch. B-4, Line 18

(1) Any Loan acquired and paid during the same month must be included on the last day of the month.

(2) Cost of fixed assets must be the monthly figure determined as the year end amounts are determined for Schedule D, Part 1, Column E. Amounts limited for DEFRA provisions may be included here. Workpapers must be available at the facility to support the amounts reported.

16	Interest — Unrelated Parties Schedule E, Part 1, Column J, Line 11	
17	Average Loan Balance — Unrelated Parties Column E, Line 15	
18	Average Interest Rate Line 16 ÷ 17 Use for all Lines of Column I	

SCHEDULE E-1
LOAN SCHEDULE ADJUSTMENTS

	A Adjustment Description	B Increase of Loan Amount	C Decrease of Loan Amount	D Sch E, Prt 1 Line to Adjust
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

SCHEDULE E-1
LOAN SCHEDULE ADJUSTMENTS

	A Adjustment Description	B Increase of Loan Amount	C Decrease of Loan Amount	D Sch E, Prt 1 Line to Adjust
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				

This schedule is to be used only for adjustments to Schedule E, Part 1.

Similar schedules are included for other parts of the report.

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SCHEDULE F
LEASES

PART 1: Leases and Lease Adjustments

1	Assigned Lease Number	Number:	Number:	Number:	Number or Total:	If any lease was originated, renegotiated or otherwise changed during the report period include ONE copy with submitted report. Record the totals in the last column of the last page.
2	Leasing Company or Individual					
3	Items Leased					
4	Cost Included on Trial Balance					
5	Check Line that applies:					
	a) Related Organization					
	b) Facility Leased after 7/31/82					
	c) Lease Purch. (Per HIM-15, Sect 110.b)					
	d) Sale and Lease Back					
	e) Other					
	For each lease checked on Line 5a, 5b, 5c, or 5d, complete a Part 2 and complete Lines 6 thru 18 according to instructions on Part 2. For each lease checked on Line 5e do not complete Part 2 or Lines 6 thru 18.					
	Cost to Reduce:					Transfer Totals to:
6	Building and Perm. Equip. Lease					Schedule B-4, Line 22
7	Vehicle Lease					
8	Other Long Term Lease					
	Cost to Allow:					
9	Depreciation					Schedule B-4, Line 23a
10	Interest					Schedule B-4, Line 23b, and Schedule E, Part 1, Col. J, Line 10
11	Other:					Schedule B-4, Line 23c and d (and additional lines 1 to 20, as needed).
12						
13						
14						
15						
	Other Ownership Data:					
16	Asset Cost					Schedule D, Part 1, Col. E, Line 27
17	Beginning Loan Balance					Schedule E, Part 1, Col. E, Line 10
18	Ending Loan Balance					Schedule E, Part 1, Col. H, Line 10

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SCHEDULE F
LEASES

PART 2

A separate Part 2 must be completed for each Lease on Part 1 checked on Line 5a, 5b, 5c, or 5d. Do Not complete if Line 5e is checked on Part 1.

1 Lease No. Assigned From Part 1 No.:	2 Total Lease Cost

3 Complete this item if Line 5b is checked on Part 1.

a. Does the lease require the owner to provide a statement of ownership costs for each report period?
☐ Yes ☐ No

b. Does the lease require the owner to make records available for audit by the Nebraska Department of Health and Human Services, the U.S. Department of Health and Human Services or their designed representatives?
☐ Yes ☐ No

c. Was a statement of costs provided by the owner for this report period?
☐ Yes ☐ No

If any of the above are no, enter 0 for items 4, 5 and 6.

If Line 5a is checked on Part 1, complete items 4, 5 and 6 based on related owner's actual costs and transfer totals to Part 1.

If Line 5b is checked on Part 1, complete item 3, complete items 4, 5 and 6 based on owner's cost.

If total owner's cost is less than the lease cost transfer amount to Part 1 —
OR
If owner's cost is more than the lease cost DO NOT transfer the amounts to Part 1.

If Line 5c is checked on Part 1, complete items 4, 5 and 6 based on amounts as if leased items were purchased.

If total owner's cost is less than the lease cost transfer amounts to Part 1 —
OR
If owner's cost is more than the lease cost DO NOT transfer the amounts to Part 1.

If Line 5d is checked on Part 1, complete items 4, 5, 6, based on amounts had title not been transferred.

Tranfer totals to Part 1.

4 Depreciation Schedule — Only leased assets used in Long Term Care. Include only allowable amounts.

Property Descriptions	Date Acquired	Asset Cost	Salvage Value	Useful Life	Depreciation	Accumulated Depreciation
Totals						

5 Loans and interest — Only include loans related to the leased assets used in providing Long Term Care Services. Include only allowable amounts.

Source/Security	Date of Origin/Maturity	Original Amount	Rate	Beginning Balance	Ending Balance	Interest
	/					
	/					
	/					
	/					
	/					
	/					
	/					
Totals						

6 Other Costs related to leased items used in LTC Svs. Incl. only allow. amts.

Category/ Account	Amount
Total	

PREPARER ACKNOWLEDGMENT

The Nebraska Department of Health and Human Services Finance and Support expects any individual or organization preparing the Long Term Care cost Report to have or obtain knowledge of the accounting principles and practices of the long term care industry and the reporting requirements and regulations governing the Nebraska Medical Assistance Program for long term care reimbursement; to discuss regulatory limitations and unallowable cost items with the provider's management; and to issue a report including disclosure of all known variances from the reporting requirements and regulatory requirements of the Nebraska Department of Health and Human Services Finance and Support.

I/we acknowledge that I/we read the above statement and, accordingly, prepared the accompanying Long Term Care Cost Report for_____ (Provider Name)

_____ (Provider Number) and issued the appropriate report on the preparation of the cost report.

SEE ATTACHED_____REPORT.

Signature	Firm	Date

CERTIFICATION OF OFFICER, OWNER, OR ADMINISTRATOR

The long term care provider participating in the Medicaid Long Term Care Program is responsible for accurate preparation of the Cost Report. Engagement of a certified public accountant or firm of certified public accountants to compile the report does not relieve that responsibility. The provider must inform the individual or firm engaged of all unallowable items included in the financial statements and other items, which otherwise unidentified, will result in securing Medicaid reimbursement over or under the amount permissible by the regulations of the Nebraska Medical Assistance Program.

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THE COST REPORT MAY BE PUNISHABLE BY CIVIL AND/OR CRIMINAL PENALTY, FINE OR IMPRISONMENT UNDER STATE OR FEDERAL LAWS.

I certify that I read the above statements and that I examined the accompanying cost report and supporting schedules prepared for_____ (Provider Name)

_____ (Provider Number) for the cost report period beginning_____and ending_____.

To the best of my knowledge and belief, the cost report is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions. All salary and non-salary costs presented in the report as a basis for securing reimbursement for Medicaid clients were incurred by the provider to deliver patient care. I also understand that all information in this report and all attachments may be subject to reviews and/or audits by the Nebraska Department of Health and Human Services Finance and Support, the U.S. Department of Health and Human Services or their designated representatives. All books, records and supporting documentation related to the information reported will be available for reviews and/or audits for the time period required by the Nebraska Department of Health and Human Services Finance and Support.

Signature	Title	Date